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COMMUNITY MENTAL HEALTH IN A RURAL REGION

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COMMUNITY MENTAL HEALTH IN A RURAL REGION

Guidelines for the development of mental health services in sparsely populated rural regions have not yet emerged. A search of the literature reveals the paucity of research on the subject. Such articles as exist are largely confined to foreign journals: Russia and China, in particular, have made serious efforts to provide adequate health services, including mental health programs, to rural peasant populations. Increased interest in the planning of rural health programs is apparent in recent U.S. publications. However, authoritative studies describing models for delivery of rural mental health services are rare; exceptions include those of Kiessler, who was able to supply both definitive and preventive services through consultation to caregivers, and Libo (1966), who developed a community consultation program in rural New Mexico. The lack of mental health services in rural regions is paralleled by a lack of health services in general. A recent evaluation of neighborhood health centers compared urban and rural centers on demographic and socioeconomic variables, health use characteristics, and health indicators. The most significant differences seemingly involved the availability of health services and the distances from such services in rural, as compared to urban, areas.

In both health and mental health rural populations are disadvantaged

by (1) a lack of services, since health facilities tend to be located at population centers; (2) a lack of professionals, most of whom cluster around metropolitan training centers; (3) a lack of transportation, since travel by automobile up to 100 miles or more may be required to reach some specialty health services; (4) a lack of integration of services, which tend to be overlapping and fragmented in rural areas; and (5) a lack of involvement of professionals, who rarely understand or participate in rural affairs. However, rural areas provide certain advantages for the health worker. (1) He is welcome wherever he goes and his services are highly valued. (2) He finds more cohesive networks for communication and service to assist him, and informal caregivers who may become staunch allies. (3) His pioneer role in penetrating the community may facilitate innovative program development.

Each small rural community, like a neighborhood in a city, presents unique characteristics and needs. The physical and emotional isolation so characteristic of the rural region renders a public health approach essential if community mental health is to reach the people, merge scarce resources, surmount barriers of poverty, overcome ethnic bias, distance, and culture, and eventually provide effective service for the entire population.

Delivery of Services in a Rural Region

Need for Decentralization

The community mental health center model is dedicated to narrowing the gap between services and consumer. As the effectiveness of reaching out into the community to provide necessary services was recognized, programs were developed at the local level in both urban and rural areas. Changes from centralized to broader community service have proceeded slowly, however. Predictably, the recipient favors neighborhood delivery of health service far more than the provider, although the opposite trend is apparent when professionals follow clients to the suburbs of large cities to provide local service. To leave the security of a successful office or clinic practice and provide service in the community is a risky step for the professional who fantasies reduced status, job insecurity, social stress, and other anxiety-provoking problems. Leaving the city to live and work in a rural region is even more threatening; yet, rural programs cannot develop unless professionals are willing to relocate. Despite the need, professionals in the health areas continue to be in short supply in rural areas; thus far, efforts to relocate physicians through training subsidies have been disappointing.

In the People's Republic of China extensive rural services were developed, involving the rotation of urban planners, teachers, and clinicians to the rural areas for periods of nine months or more. American observers seem to interpret the rural assignments as punitive in nature; however, no criticism from those involved could be detected, and the success of the program was attributed to patriotic fervor. Effective use of indigenous

workers was illustrated by the wide variety of tasks performed by the "barefoot doctor," and by other local organizational features of the Chinese program. The direct field experience of living and working in a rural area enabled policy makers and trainers to become familiar with class and cultural differences, and to mobilize relevant community resources.

In the United States, a reverse trend is noted: Planners rarely visit the rural community in person and health resources are largely found in urban areas. In rural regions an inverse relationship exists between quantity and quality of service and physical distance from providing agencies: Patients are expected to travel to population centers for all their health care needs. Rural upper and middle classes adjust to such financial and distance barriers, but for rural low-income families, the required travel may be an almost insurmountable burden: Problems of unreliable automobiles, expense, loss of work time, babysitting, long waits at the clinic, and so on. The rural poor are thus effectively prevented from seeking help, except for their most serious and urgent needs.

To provide quality health services in rural areas, the delivery of human services must be combined; it is unthinkable, for instance, to deliver quality mental health care to one family member and to ignore a tuberculosis victim, or a child with a toothache, in the same family. Schools, as centrally located care-giving agencies, could provide space for comprehensive services.

Professionals, planners, and politicians must be convinced of the necessity for the relocation of services from traditional centralized settings to the rural community. The bias against providing such services is evident when officials disclaim the problem, blaming the individual "who could get to the [distant] facility if he were truly motivated or sick enough." Such prejudice must be overcome and strategies must be developed for reaching and treating all sectors in each community.

Design for a Rural Mental Health System

The following ideal goals were abstracted from the Tulare County (California) Five Year Plan for Mental Health (1970):

1. Provision of immediately available mental health service to each community grouping of 500 to 1,000 population.

2. Delivery of services to include a maximum of participation by indigenous community persons.

3. Integration of all human services into a unified delivery system.

4. Development of an informed and understanding community.

To provide immediate, appropriate mental health services in a rural area requires a network of small units, each offering a wide range of services, including diagnosis, therapy (group, family, music, activity), creative arts,

mental health consultation, medication, and other modalities. Rapid evaluation and triage allows for an individually prescribed regimen, subject to change as the patient progresses toward recovery. With a variety of available services and prompt feedback of information from initial interventions, flexible short- and long-term therapeutic goals are possible. Central backup services should include business administration; intensive care on a small ward; coordinated, mobile, emergency services; and a close alliance with other medical and social services.

Program units should be small, staffed by a few skilled professionals, and semiautonomous in function. Trained nonprofessionals and citizen participants are essential elements. The commitment to serve all patients encourages creativity and innovation, leading to a therapeutic, self-fulfilling prophecy which virtually ensures success. Such activities as planning, research, training, and recruiting require collaboration between local staff, central administration, and outside consultants. Since the unit functions at the local level, mental health-related information concerning the population served is monitored continually, allowing for frequent program modification. A systems type analysis with regular study of selected indicators offers the most precision; however, a human analysis, with intuitive feel for the community, is also required.

Outreach Programs

Home Therapy

The time-honored approach of the visiting nurse and social worker is seldom employed by the psychotherapist; however, even a brief glimpse of the home scene may reorient the therapist as he becomes aware of factors not revealed in hospital or clinic visits. Significant other persons in the patient's social system are immediately available and frequently participate in the interview. Scheduling difficulties are simplified, particularly in family therapy, which is most effective when conducted in the home.

Neighborhood Therapy

Neighborhood therapy, a variation of home therapy, is effective in some communities. The customary need for privileged communication would seem to preclude neighborhood intervention, especially in the small rural community. However, in most instances the suggestion is warmly received by both the patients and their families. Acceptance is explored with each family until a neighborhood group is established. Meetings are held in a home or some other convenient place. Group members assume responsibility for planning and arrangements, and the therapeutic session frequently includes social and recreational activities. A loose therapeutic community is thus created, extending beyond the therapist and the session. Significant others, previously unknown to the therapist, join the group informally, and a supportive network is developed to assist rehabilitation of group members.

Special features of neighborhood therapy are that the neighborhood group has (1) longstanding relationships, (2) common interests and goals, (3) continuing therapeutic alliances, (4) its own emotional resource system, (5) the opportunity to study therapeutic successes and failures at first hand, (6) the power to accept or reject the patient, and (7) the capability to reduce the stigma attached to the mentally ill.

The Satellite Clinic

With community cooperation a small, local, clinic facility may be established. The satellite approach is sometimes needed to develop meaningful services for a disadvantaged group that is unable or unwilling to use services offered at the mental health center. The clinic may initially operate only part-time while it bids for acceptance by the community. Services are patient and family centered, and carefully chosen indigenous workers form the core staff. Informal training experiences should be provided for community workers in the parent facility and in other community agencies. Cultural and sometimes language barriers must be bridged to accomplish the first goal of developing a meaningful communication system, a process that cannot be hurried or controlled. Once trust is established, clinical experiences customarily prove much the same as those encountered in conventional settings: Patients somehow seem more human and emotional problems less unusual.

The Community Team

An alternate method, the community team, functions much as the satellite clinic, but without a fixed base. Team members travel to isolated communities bringing components of the mental health program that seem most acceptable and appropriate for local needs. As in the satellite clinic, the team should include nonprofessionals and volunteers from the community who assist in linking the consumers to the professionals. Crisis intervention techniques and the "anywhere" consultation, when used creatively, enable most clients to be managed as outpatients. For those who initially require hospitalization, the team can play a key role in follow up and rehabilitation.

The Community Representative

A carefully selected community representative is a valuable addition to any outreach program. In the small, rural community a volunteer or resident employee in the community can provide a variety of services otherwise seldom obtainable. Acting primarily in a liaison role between community and mental health center, the worker communicates with each. Emergency and crisis intervention services are enhanced by the ready availability of a staff member in the community; many aspects of both activity therapy and rehabilitation can be delegated to the indigenous helper. The community representative is both a spokesman and an informant, helping to build favorable relations between the mental health center and the public.

Professional staff members may, at first, find it difficult to accord the local worker equal status and respect. Experience soon demonstrates the lack of role conflict, however, and much creativity can evolve from the shared program development that results.

In areas characterized by great distance between population centers, strategically located community representatives, working part-time with professional staff from the treatment facility, can form a network of services. The presence of a visible, reliable resource in the community reassures both patient and professional, adding stability to the total program. The community representative provides invaluable assistance in prevention programs, disseminating mental health information and education on a formal and informal basis by showing movies, distributing literature, and talking to groups. In reaching ethnic minorities where cultural and language barriers are difficult for an outsider to breach, a community representative can be an indispensable ally.

An Example: Kings View Rural Mental Health Services

Kings View Community Mental Health Center at Reedley, California, a private, nonprofit corporation, has established contracts to provide decentralized programs with five San Joaquin Valley counties under California's Lanterman-Petris-Short Act. Since 1969, services have been

extended to a rural area of about 12,000 square miles, with a population of approximately 400,000. Mental health units, consisting of two inpatient facilities (twenty-six and sixteen beds, respectively), seven day treatment centers, and ten outpatient clinics, were installed in rural population centers. Instead of construction, leased or donated facilities were used. Immediate, appropriate services were provided, including crisis intervention, medication, individual therapy, group therapy, family therapy, activity therapy, rehabilitation, and outreach service. An individualized plan was established for each patient, with emphasis on continuity of care. The day treatment center provided definitive care for more seriously disturbed patients; when necessary, patients were hospitalized briefly (average seven to ten days) for stabilization, then transferred to the day treatment unit nearest to their homes. The system has provided quality inpatient and outpatient care for all identified patients: 7,000 cases were treated annually, as compared to the approximately 400 committed annually to California State Department of Mental Hygiene Hospitals in a previous year. The need for more outreach services became evident when statistics revealed that proportionate numbers of lower-class patients were seen by the hospital and emergency services, but relatively few obtained outpatient or indirect services. Scores of smaller settlements were receiving no local services; a search was initiated for more appropriate, community-based interventions, which soon led to a greater appreciation for, and understanding of, rural needs.

The Kings View experience has dispelled a number of myths about the chronic or long-term patient. Early evaluations demonstrated that acutely ill psychotics responded promptly to the intensive treatment program, but anxiety developed about management of the hardcore patient. Could the new system cope with the problem or would a new back ward finally be required? Eventually, the hard-core patient emerged as a repeater at the inpatient unit, who had somehow slipped past the network of outpatient services. A criterion was established, and special follow-up techniques were devised to cope with this target group: Home visiting, informal group meetings, social network therapy, injectable medication for those unable to follow instructions, hot pursuit for the excessively mobile, and so on. Patients' families, who at first were uncooperative, became allies when assured of the therapist's sincerity and of the reliability of the emergency services. As a consequence, disability was reduced and hospitalization was rarely required.

Encouraged by success, more interest and concern were generated for the chronic patient, and other subcategories, released from institutional care without follow up, were discovered: Veterans' Administration patients, parolees from the California State Correctional System, criminally insane and sex offenders released by the California State Department of Mental Hygiene, and board-and-care patients under supervision of the community services branch of the California State Department of Social Welfare. Supportive and rehabilitative efforts for all such patients were coordinated into the mental

health system, with emphasis on the patient's adjustment to the community rather than to the institution.

Community Approaches

Traditional Prevention Services

In rural communities, consultation to schools, pre-and postnatal clinics, visiting nurses, family planning services, and other agencies is readily accepted. Priority should be given to consultation with Head Start and child-care centers: Joint programming for early identification of children with emotional and learning handicaps has an immediate payoff to both mental health and the schools. Mental health information and education through films, mass media, tours, adult education programs, special workshops, and other means should be planned systematically to involve both the public and the care-giving agencies.

Integration with Other Agencies

A close working relationship with other human service agencies is essential in rural regions. Because of the paucity of services, lack of cooperation is more visible and destructive than in the city, where a variety of programs are available. Since rural resources are meager, interagency contacts are easily established. Following a favorable consultation period,

joint programs may be developed that will provide service that is superior to that produced by either agency working alone. Domain boundaries become blurred, and new opportunities are discovered. The mental health center may at first furnish leadership in the venture because of the skills of its staff in group and interpersonal relations; later, the program will be truly a joint enterprise. In Tulare County a successful probational mental health crisis team, based at the mental health center, was formed using staff members from both agencies. Referrals to the probation department were diverted to the team, which intervened promptly in the home and in the school.

Serving the Entire Population

An essential feature of a successful, rural, mental health program is the commitment to serve the whole population and to supply immediate, appropriate treatment to all those in need. Any lesser commitment encourages defensive restriction of services at every level. To accomplish the program's objective, understanding of the small rural community as a social system is essential. A participant observer survey combined with anthropological consultation facilitates the understanding of the many cultural differences encountered. The classic studies of Goodenough and Paul provide useful clues to exploring the community. Unless cultural factors are considered, planning and administrative errors are predictable and will be repeated by each new program. Reports explaining the Mexican-American

culture have contributed to the understanding of communities in California; however, each community must be studied as a separate entity, and programs developed must be acceptable in terms of each community's folkways and mores.

Establishing Meaningful Contact

Valid assessment of the community is possible only through human interaction. Building trust is a prerequisite to success, and the mental health worker's attitude may be a critical variable. Early impressions are often misleading; significant information is released only after the intervener has proven himself trustworthy in the ways the community has tested him. Culturally biased views, if any, may be immediately apparent to community members, and months of regular contact may be required before the mental health practitioner and the community resolve mutual prejudices and misconceptions.

Customarily, mental health professionals avoid political activity, but in the rural community, political involvement may be necessary. The mental health intervener will exercise political influence either knowingly or unknowingly; if the political aspect is defined as a constructive intervention, rather than as dangerous or unethical, the program's development may be facilitated. A responsive and responsible mental health worker may be

invaluable to the community in obtaining its objectives and in avoiding political pitfalls.

Community Participation in Planning

Typically, health planning is initiated from above and proceeds downward: Federal and state planners determine health needs and resources in rank order; cost effectiveness, available manpower, political considerations, and budgetary restrictions are predicted; funding is secured; and, finally, a rational plan is developed for presentation to community leaders. The consumer's right to be involved is acknowledged; however, he is rarely present or represented during deliberations. Unfortunately, many well-designed, well-intentioned programs are unsuccessful because prior experience in the rural region has been neglected and potential sources of difficulty have not been identified. Service programs designed under government or university auspices may contain a hidden agenda (career building, research, political manipulation) that automatically precludes an egalitarian, creative relationship between intervener and community. New models are needed, both to involve the community and to encourage participation in planning by all concerned.

One alternative to the traditional model depends on consumer participation, effectively reversing the traditional approach. Axioms of this

method are: (1) Act now, plan later. (2) People come before program. (3) Deemphasize money and construction. (4) Prepare for predators. (5) Proceed aggressively.

Act Now, Plan Later

Community members, bored with unfulfilled promises and program failures, nevertheless remain willing to become involved in action programs that are considered appropriate to felt needs. Such programs can be initiated immediately and planning continued as development proceeds under the direct supervision of the community. Prompt feedback concerning problems and failures allows for correction of undesirable trends as they arise. Goals and design of the program are changed as needed until a functional fit that is acceptable to both community and professional is achieved.

People Come Before Program

The first goal in planning a program should be to engage all concerned in a working partnership and to secure full community sanction. Professionals should advise sparingly, allowing the community to share in designing and developing its own program. Communication between consumer and planner and a creative climate for community development are the ultimate goals.

Deemphasize Money and Construction

Funding is an essential element, but should never dominate planning. Guidelines of a grant proposal may impose an artificial bureaucratic burden on the planning process and stifle creativity in program development. An all-voluntary effort, on the other hand, is easily initiated, is flexible, and allows more degrees of freedom. When money needs are deferred, unexpected benefits sometimes appear. Resources may be mobilized from within the community so that funding proves less important than anticipated; as a result political power is retained by the community. The interest and energy customarily devoted to grant-writing procedures become available for community dynamics and human interaction. Community leaders who identify themselves with the voluntary program frequently have different goals and values as compared to those who identify with the publicly funded programs; later when the program matures so that funding is introduced, the voluntary leader usually proves more reliable and effective. Confrontations and power struggles, so often identified with outside funding, may be avoided.

Initiating construction to house programs should likewise be undertaken with caution. Once completed, a structure may fixate the program. The trend in mental health toward local treatment and phasing out of institutional services is apparent in California, where several state

hospitals have already been eliminated. Increased emphasis on community-based programs can be anticipated in the future: Existing structures within the community can frequently be modified and adapted to the needs of mental health programs. Construction planning, delays, and costs are avoided when facilities are leased rather than purchased. The community should assist in the selection of appropriate existing structures, thereby ensuring community acceptance and increasing the probability of success for the program.

Prepare for Predators

When a community-developed program shows signs of success, a variety of outside professionals and politicians may attempt to get some of the credit or perhaps to undermine the fledgling operation. From a systems theory viewpoint, violation of a domain boundary is seldom involved; rather, the outsiders seem motivated by fear of change and seek to restore a presumed equilibrium in the delivery of service. Forewarned, the community planners may be able to involve the invaders constructively in program development, since services are so welcome in the rural area.

Proceed Aggressively

Once initiated, the community program develops an identity and dynamic force of its own. As participants are recruited, a movement is

generated which requires the coordinated expertise of both mental health workers and community leaders for its successful management. Good timing and a feel for community sentiment are important variables. Effective use of expert consultation and outside support to implement planning and program development enhances movement toward the goal.

Community Participation in Program Development

The core component in rural community mental health program development is the citizen participant. Volunteers from the community play a vital role in program planning and development, disseminating meaningful mental health information and education to the public, and arousing community support. Innovative programs invariably require citizen participation, as well as the extracurricular voluntary efforts of staff members. Creative solutions to rural mental health problems cannot be purchased; exciting components arise from the cooperative efforts of all concerned.

The emergent role of the citizen participant in health and other human services has not been clearly defined. The modern volunteer is motivated primarily for self-actualization and career development. He is effective in his own life and seeks meaningful use of his talents. The chief barriers against using volunteers in ongoing service programs arise from the covert resistance

of professionals, who fear a loss of prestige, and from the failure of administrators to consider the volunteer's personal needs, which might be quite different from those of the regular employee. Too often, the volunteer is given a useful but nonthreatening and perhaps meaningless role that effectively stifles creativity and extinguishes interest.

Rural mental health programs require a volunteer director who functions at the policymaking level in the organization. Duties include (1) recruitment and training of volunteers, (2) design of volunteer components for each project, (3) mediation between volunteers and professionals, (4) development of meaningful careers for citizen participants, and (5) promotion of additional volunteer human service programs in the community. Potential for prevention exists in the volunteer coordinator's ability to facilitate new volunteer programs. The newly established and rapidly expanding volunteer court movement is an outstanding example.

Informed citizen participants can interpret the program's goals, needs, failures, and successes to the rural public far more effectively than professionals. Volunteers sometimes provide services not otherwise obtainable (for example, volunteer foster homes or evaluation of programs) and can assist the mental health center in the management of difficult cases, the development of prevention programs, and the resolution of political problems. Operationally, a constant interaction between the mental health

center and citizen participants should be the rule in rural regions.

Volunteer bureaus are easily established in small rural communities, providing a pool of volunteer talent to be matched with service opportunities. With many volunteer positions available, the citizen participant can select an appropriate and stimulating role. As citizen participants develop an understanding of mental health principles and community problems, a growing constituency is formed to advocate for social change and furnish leadership in new community ventures.

A Community Alcoholism Program

The evolution of the Tulare County Alcoholism Council illustrates vividly the role of volunteers in community program development. Comprehensive programs for prevention and treatment of alcoholism are notoriously difficult to organize because of vested interests of service agencies and public denial of the problem. The planning process in Tulare County was initiated by the Mental Health Advisory Board; public meetings were sponsored to deal with the joint topics of alcoholism and drug abuse. Representatives of involved agencies, as well as interested citizens, attended the initial meetings. A decision to divide into interest groups led to the formation of a planning committee for alcoholism charged with investigating the current status of the problem in Tulare County. A talented housewife,

formerly a teacher, volunteered as chairman, and others agreed to share leadership responsibilities. Members of the committee included one or more representatives from each local agency, representatives from Alcoholics Anonymous, volunteers from the general public, and individuals who were motivated by family or personal experience with alcoholism.

A survey of needs and resources was conducted by a social work graduate student who worked with members of the committee and with participating agencies. A comprehensive plan was developed which included both short- and long-term goals. Immediate steps were taken to raise funds for an alcoholism halfway house, to improve an alcoholism education program in local schools, and to establish detoxification facilities. The chairman and other volunteers made brief presentations throughout the county to service clubs, churches, and other civic organizations in an effort to reduce the stigma associated with alcoholism and to secure public endorsement. The political effectiveness of the committee's approach was demonstrated when the Tulare County Board of Supervisors voted unanimously to sponsor the program. Other alcoholism programs in the state were visited and funding agencies contacted by the chairman and members of the committee.

As support from the public and board of supervisors increased, the organization was incorporated, and the alcoholism council was able to obtain

development funds. When legislation was enacted recently authorizing the diversion of public alcoholics to detoxification centers rather than to county jails, the council was ready with a master plan for a comprehensive alcoholism program. Mental health continues to play an active advisory role, but major credit for planning and development of the program must be given to the talented and dedicated volunteers.

Community Development Programs

In rural areas, mental health-related programs require broad community support in coping with prejudice and other barriers to social change. Comprehensive programs for children, senior citizens, alcoholics, drug abusers, the mentally retarded, and those with learning handicaps require the combined action of all available agencies and the dedicated support of concerned citizens. Acting alone, the mental health center cannot supply adequate services. However, leadership and organizational skills may be provided for the development of new projects, and mental health workers can advocate for the elderly, for children, and for disadvantaged groups who lack political power.

To provide leadership for rural projects, especially to those disadvantaged by poverty and/or ethnicity, is a difficult task. A total community approach is most effective, one in which the professional

consultant temporarily sets aside his personal goals to work with the community on a program of its own choosing. Success of the program increases the self-respect and self-confidence of community participants (in itself a significant mental health achievement) and leads to other self-help projects. Using Caplan's model, the small rural community may be considered a consultee, much the same as an institution; similar techniques may be employed for entering the community, building positive relations, and developing a consultative role. Mental health projects may be introduced after the consultant has gained credibility and acceptance in the community.

Examples of Creative Partnership for Community Development

The Tule River Indian Reservation

My first contact with the Tule Indians was made on an informal visit to the reservation. Asking directions of a resident, I introduced myself and was directed to the tribal council headquarters, where I met two resident health aides who had been trained in an earlier health program. An invitation to a tribal council meeting resulted. In this, and subsequent meetings, I learned about current problems and had the opportunity to review the various proposals of public officials, businessmen, researchers, and others who had come to the reservation. A long series of projects had been attempted on the reservation, but nearly all had failed after a short time. One exception was the

water system, which the public health engineers had been constructing over a period of fifteen years. Personnel and other bureaucratic changes had repeatedly delayed completion of the project; consequently many families were still carrying water from the river for household use. At the council meeting I was given the opportunity to explain my role in mental health and to offer assistance to the tribe in a project of its own choosing.

In subsequent discussions, priority was given to establishment of a dental clinic on the reservation. Although the furnishing of dental services would seem to bear little relationship to mental health, in order to honor my commitment, I explored possibilities for a dental clinic both with tribal leaders and with resources in the larger community over a period of several months. As a result of these efforts, plans for a voluntary dental clinic gradually evolved. A dental group from nearby Visalia, California, offered voluntary service on a regular basis; one of the dentists assumed the role of project coordinator. Other community resources became available; an architectural firm offered to draw plans for remodeling a tribal building to house a medical-dental facility; a dental supply firm furnished necessary equipment; the regional building trades council arranged for a volunteer labor force; and the U.S. Public Health Service supplied plumbing materials. Problems were encountered in obtaining donations of building supplies from dealers and wholesalers, but eventually a few cooperating firms were located.

The preparatory process required considerably more time than anticipated, but continued contacts with tribal members created opportunities for consultation on other matters. A volunteer medical student spent the summer on the reservation and assisted in expediting the project. The need for a dental assistant was paramount; however, unsuccessful academic experiences at nearby colleges in the past had resulted in a reluctance on the part of Indian youths to seek the necessary training for participation in tribal projects. Consequently, training on an informal basis was arranged for three female aides: (1) a medical aide was trained for six months in a general practitioner's office, with three additional weeks at a general hospital emergency room; (2) a dental aide was trained by the participating dental group in its main offices; and (3) a mental health aide was trained in the nearest Tulare County outpatient and day treatment center, with brief experience in an inpatient unit.

Consultation was requested by the tribe on a variety of matters. The health aides requested assistance in the following areas: preparation of a revised budget for the health project, development of an efficient medical record system, writing proposals for a health insurance program, and development of an evaluation program. Volunteer specialists were recruited to fill each request. As tribal leaders gained experience and confidence, other projects were successfully completed at the reservation, including a children's playground, a general store and service station, and the remodeling

of a tribal building for a child-care program. A noticeable improvement of skills in dealing with the larger society emerged over a period of time. Negotiations with representatives of supply companies and unions concerning the clinic construction furnished valuable learning opportunities. Contacts with the statewide Indian organizations increased; tribe members were chosen for state Indian offices. The tribe sponsored a large fund-raising program in a nearby city, “An Indian Happening,” the first of its kind in the area.

The favorable change in attitude and outlook of individuals in the tribe as a result of the successful projects was noticeable. Consultation requests became more sophisticated, telephone contacts increased, and meetings were occasionally held off the reservation. Even though construction of the medical-dental facility was delayed, the dental program was established in temporary quarters and became an immediate success. The dental aide worked with the dentists at the reservation and continued her training at their offices on a part-time basis. Federal Indian health funds became available and were used to hire a dentist to supplement the volunteer program. The physician who trained the medical aide encouraged her to undertake a medical prevention program that involved the collection of health histories and the administration of screening tests for diabetes and hypertension. A family planning clinic was introduced through the child-care program. An eye clinic was sponsored by the health department, and other

specialty clinics were planned for the newly remodeled facility as it neared completion. The development of mental health services on the reservation was never discussed. Subsequent to her training, the mental health aide confessed that her assignment was the most frightening of all and that she was terrified during her first visits to the day treatment center. Her inner turmoil was not suspected by the mental health staff, who were impressed by her ability.

The need for mental health service has remained low in priority, but tribal members are now serving on the Tulare County Mental Health Advisory Board and the Tulare County Alcoholism Council, both policy-making boards, thus providing a direct link between the reservation and the mental health system. Although traditional mental health consultation was not the focus of the consultation relationship, the intervention is an example of primary prevention: Successful health programs have been developed on the reservation, the Tule River Indian health project has many trusted advisors, and some of the barriers to provision of health and mental health care have been lowered.

Earlimart, California

An intervention, similar to that of the Tule reservation, was attempted in a low-income area of southern Tulare County (approximately thirty square

miles, population 14,-000). Farm labor, which is seasonal, provides the chief source of income. Human services of all types are virtually nonexistent. Ninety percent of the population is medically indigent, and approximately one-half receive some form of public assistance. Earlimart (population 2,900) is the largest community and is central to the service area.

The community was explored through several unrelated interventions. In the first, consultation was furnished to a young pediatrician who established a poverty clinic, Salud Earlimart. The clinic was the only medical resource in the area, and bilingual health aides were employed to facilitate treatment of the largely Spanish-speaking population. The consultant psychiatrist visited the clinic weekly, developing a consultation relationship and providing direct service to clinic patients. The informal partnership led eventually to formation of a satellite mental health center. Services were gradually extended outside the clinic into the community, and to other population centers in the area, by a mental health team.

The second intervention involved Catholic Sisters, assigned as poverty workers to establish social and educational services in Earlimart. Regular consultation with the Sisters afforded additional opportunities to learn about the community. A third community contact was established through consultation with a psychologist serving the Head Start childcare program. A fourth intervention was initiated by the Tulare County Mental Health

Advisory Board when a public forum was conducted to discuss mental health service needs with area residents.

Eventually the consultant was invited to meetings with all ethnic groups (black, Mexican-American, Anglo, Filipino, and so on) to explore community concerns; again the offer was made to assist the community with a project of its choosing. The highest priority, in this instance, was the need for a drug store (none being available in the area); the need for dental services ranked a close second. Developing a drug store proved to be an insurmountable problem; however, a community development was undertaken with the goal of establishing a free dental clinic. Free equipment was supplied by a dental supply firm, and dentists from several cities volunteered to serve twice monthly after the program was developed; one volunteered as coordinator, devoting two days per week of his time during the developmental phase. A board, representative of all communities in the area, was selected at public meetings to consult with the involved professionals and to determine clinic policies. The organization recruited community volunteers for fund raising, staffing of the clinic, and other aspects of the program. The Catholic Sisters of Charity furnished a house trailer for the clinic operation and worked with the volunteers in developing clinic procedure. Although inexperienced, the board made surprisingly effective decisions, each time reviewing the issues carefully with the professional advisors. Community sanction was evidenced by massive voluntary efforts and large attendance at fund-raising dinners,

rummage sales, and the like. Gradual progress led to formation of a nonprofit corporation and plans for a building program.

Mental health services were expanded slowly in the community, with recognition that such services are threatening and difficult to introduce in a low-income, ethnic minority rural area. A favorable public image gained by assisting the successful dental project dispelled to some extent the mystique ordinarily associated with psychiatric treatment. Initially, group therapy sessions were conducted at the clinic, and outpatient services offered on a weekly basis. As the program developed, patients were seen in homes, in restaurants, in automobiles, in churches, or in any mutually convenient location. Neighborhood groups were started in nearby communities. The initial participants were chronic patients, who were enthusiastic about the opportunity for local treatment; soon new patients and their families joined the groups.

Two local residents, one Spanish-speaking, were employed for part-time service and were trained informally at other therapy centers in the county. One served as a volunteer coordinator in addition to other duties. Both were available for crisis intervention, expediting of individual treatment plans for patients, community work, and so on. A staff social worker began consultation with local school districts. Later a small house, near the Clinic, was rented to provide space for day treatment services. Services that formerly required a

round trip of fifty miles or more became available at the local level, but the planning and development process was continued to ensure acceptable delivery of mental health service. Innovation and program change were encouraged with patients, aides, volunteers, and professionals collaborating in the planning. Opportunities for development of new projects continued to emerge, and models for delivery of rural mental health services have been improved as experience has been gained in the field.

Trends

Rural delivery of mental health services has received an impetus from several sources. The federal community mental health centers program, which stresses delivery of services at a local level, has demonstrated the feasibility of alternate models to the traditional centralized system. In California, Lanterman-Petris-Short legislation has encouraged innovation and decentralization in pursuit of its goal of developing a single system of local mental health service. Rural regions have benefited along with urban and suburban areas. Finally, the current interest in health maintenance organizations, which would provide comprehensive health care through a system of national health insurance, may prove to be an additional stimulus to development of rural mental health programs.

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